

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0040535</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Harmony Nursing And Rehab</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>3919 West Foster</u> <u>Chicago</u> <u>60625</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Cook</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(773) 588-9500</u> Fax # <u>(773) 588-9533</u>		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) <u>Noshir R. Daruwalla, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>	
IDPA ID Number: <u>363969873001</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>12/14/94</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Steve Lavenda</u> Telephone Number: <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsn/a

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,700</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,395</u>	<u>1,863</u>	<u>6,071</u>	<u>12,329</u>	8
9	SNF/PED					9
10	ICF	<u>33,663</u>	<u>14,978</u>	<u>20</u>	<u>48,661</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>38,058</u>	<u>16,841</u>	<u>6,091</u>	<u>60,990</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 92.83%

D. How many bed-hold days during this year were paid by Public Aid?

625 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 12/14/94

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 5/25/94NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 39

and days of care provided

6,071Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒NO ☐Tax Year: 12/31/03Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Harmony Nursing And Rehab

0040535

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	372,579	73,895	9,888	456,362		456,362	3,054	459,416		1
2	Food Purchase		303,829		303,829	(54,203)	249,627	(834)	248,793		2
3	Housekeeping	366,151	37,457		403,608		403,608	8,741	412,349		3
4	Laundry	65,154	31,550		96,704		96,704		96,704		4
5	Heat and Other Utilities			157,266	157,266		157,266	2,636	159,902		5
6	Maintenance	24,872	24,024	74,275	123,171		123,171	(13,298)	109,873		6
7	Other (specify):*										7
8	TOTAL General Services	828,756	470,755	241,429	1,540,940	(54,203)	1,486,738	299	1,487,037		8
	B. Health Care and Programs										
9	Medical Director			18,000	18,000		18,000		18,000		9
10	Nursing and Medical Records	2,513,575	189,226	57,135	2,759,936		2,759,936		2,759,936		10
10a	Therapy	206,162			206,162		206,162		206,162		10a
11	Activities	118,244	11,526	2,350	132,120		132,120		132,120		11
12	Social Services	208,687		4,264	212,951		212,951		212,951		12
13	Nurse Aide Training										13
14	Program Transportation			1,170	1,170		1,170		1,170		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	3,046,668	200,752	82,919	3,330,339		3,330,339		3,330,339		16
	C. General Administration										
17	Administrative	90,378		213,000	303,378		303,378	17,245	320,623		17
18	Directors Fees										18
19	Professional Services			402,068	402,068		402,068	(307,921)	94,147		19
20	Dues, Fees, Subscriptions & Promotions			95,229	95,229		95,229	(81,334)	13,895		20
21	Clerical & General Office Expenses	156,617	4,800	225,232	386,649		386,649	(27,047)	359,602		21
22	Employee Benefits & Payroll Taxes			821,309	821,309	54,203	875,512	(54,731)	820,781		22
23	Inservice Training & Education										23
24	Travel and Seminar			5,219	5,219		5,219	281	5,500		24
25	Other Admin. Staff Transportation			1,193	1,193		1,193		1,193		25
26	Insurance-Prop.Liab.Malpractice			183,051	183,051		183,051	733	183,784		26
27	Other (specify):*							40,368	40,368		27
28	TOTAL General Administration	246,995	4,800	1,946,301	2,198,096	54,203	2,252,299	(412,406)	1,839,893		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,122,419	676,307	2,270,649	7,069,375		7,069,375	(412,107)	6,657,268		29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Harmony Nursing And Rehab

#0040535

Report Period Beginning:

01/01/03

Ending:

12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			37,111	37,111		37,111	455,948	493,059			30
31	Amortization of Pre-Op. & Org.							322,979	322,979			31
32	Interest			93,398	93,398		93,398	558,676	652,074			32
33	Real Estate Taxes							350,773	350,773			33
34	Rent-Facility & Grounds			1,307,070	1,307,070		1,307,070	(1,307,070)				34
35	Rent-Equipment & Vehicles			25,933	25,933		25,933	3,530	29,463			35
36	Other (specify):*							46,184	46,184			36
37	TOTAL Ownership			1,463,512	1,463,512		1,463,512	431,019	1,894,531			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	229,448	253,762	19,738	502,948		502,948		502,948			39
40	Barber and Beauty Shops			16,122	16,122		16,122	(16,122)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*	22,986			22,986		22,986	(22,986)				43
44	TOTAL Special Cost Centers	252,434	253,762	134,410	640,606		640,606	(39,108)	601,498			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,374,853	930,069	3,868,571	9,173,493		9,173,493	(20,196)	9,153,297			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab

0040535

Report Period Beginning: 01/01/03

Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	267,196	30		9
10	Interest and Other Investment Income	(71,019)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(834)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,975)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(21,766)	20		20
21	Owner or Key-Man Insurance	(54,731)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(139,547)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(513,959)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (538,635)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	518,439		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 518,439		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (20,196)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

NON-ALLOWABLE EXPENSES			Amount	Sch. V Line	Reference
1	Reclassified R&M	\$	(16,110)	06	1
2	Staff Development PR		(28,308)	29	2
3	Public Relations		(36,667)	29	3
4	Beauty Shop Income		(16,122)	40	4
5	COPY Costs		(2,608)	29	5
6	Marketing Salary		(22,986)	43	6
7	Franchise Tax - Bldg Partnership		(200)	21	7
8	Accounting - Bldg Partnership		(11,736)	19	8
9	Trust Fee - Bldg Partnership		(988)	21	9
10	Non-Allowable Legal - Retainer Fees		(6,000)	19	10
11	Prepayment Penalty - Bldg Partnership		(355,911)	32	11
12	Additional Legal Expense		375	19	12
13	Non-Allowable Legal - Out of period		(14,643)	19	13
14	Penalties		(20)	21	14
15	Collection Fees		(15,784)	21	15
16	Non-allowable professional fees		(4,800)	19	16
17					17
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100					100
101	Total		(513,959)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harmony Nursing And Rehab# 0040535

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			3,054									3,054	1
2	Food Purchase	(834)											(834)	2
3	Housekeeping			8,741									8,741	3
4	Laundry													4
5	Heat and Other Utilities			2,636									2,636	5
6	Maintenance	(16,116)		2,818									(13,298)	6
7	Other (specify):*													7
8	TOTAL General Services	(16,950)		17,249									299	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	TOTAL Health Care and Programs													16
	C. General Administration													
17	Administrative				17,245								17,245	17
18	Directors Fees													18
19	Professional Services	(26,244)	11,176	(270,754)	(22,099)								(307,921)	19
20	Fees, Subscriptions & Promotions	(81,469)		351	(216)								(81,334)	20
21	Clerical & General Office Expenses	(160,399)	1,126	130,614	1,612								(27,047)	21
22	Employee Benefits & Payroll Taxes	(54,731)											(54,731)	22
23	Inservice Training & Education													23
24	Travel and Seminar			230	51								281	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice			733									733	26
27	Other (specify):*			36,607	3,761								40,368	27
28	TOTAL General Administration	(322,843)	12,302	(102,219)	354								(412,406)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(339,793)	12,302	(84,970)	354								(412,107)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harmony Nursing And Rehab# 0040535

Report Period Beginning:

01/01/03

Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	267,196	180,072	8,680									455,948	30
31	Amortization of Pre-Op. & Org.		321,127	1,852									322,979	31
32	Interest	(426,930)	972,681	12,925									558,676	32
33	Real Estate Taxes		344,926	5,847									350,773	33
34	Rent-Facility & Grounds		(1,307,070)										(1,307,070)	34
35	Rent-Equipment & Vehicles			3,530									3,530	35
36	Other (specify):*		46,184										46,184	36
37	TOTAL Ownership	(159,734)	557,919	32,834									431,019	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops	(16,122)											(16,122)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(22,986)											(22,986)	43
44	TOTAL Special Cost Centers	(39,108)											(39,108)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(538,635)	570,221	(52,136)	354								(20,196)	45

Facility Name & ID Number Harmony Nursing And Rehab# 0040535

Report Period Beginning:

01/01/03Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	32 Interest Income	\$ 7,872	Keiro Building LLC	100.00%	\$	\$ (7,872)	1
2	V	34 Rental Income	1,307,070	Keiro Building LLC	100.00%		(1,307,070)	2
3	V	21 Franchise Fee		Keiro Building LLC	100.00%	200	200	3
4	V	36 MIP Insurance		Keiro Building LLC	100.00%	46,184	46,184	4
5	V	32 Interest Expense		Keiro Building LLC	100.00%	355,911	355,911	5
6	V	21 Office Expense		Keiro Building LLC	100.00%	26	26	6
7	V	19 Accounting Fees		Keiro Building LLC	100.00%	11,176	11,176	7
8	V	21 Trust Fees		Keiro Building LLC	100.00%	900	900	8
9	V	32 Mortgage Interest		Keiro Building LLC	100.00%	624,641	624,641	9
10	V	33 Real Estate Taxes		Keiro Building LLC	100.00%	344,926	344,926	10
11	V	30 Depreciation		Keiro Building LLC	100.00%	180,072	180,072	11
12	V	31 Amortization		Keiro Building LLC	100.00%	321,127	321,127	12
13	V							13
14	Total		\$ 1,314,942			\$ 1,885,163	\$ * 570,221	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Harmony Nursing And Rehab**# **0040535**Report Period Beginning: **01/01/03**Ending: **12/31/03**

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 DIETARY	\$	ITEX COMPANY	100.00%	\$ 3,054	\$ 3,054
16	V	3 HOUSEKEEPING				8,741	8,741
17	V	5 UTILITIES				2,636	2,636
18	V	6 REPAIRS AND MAINT.				2,818	2,818
19	V	19 PROFESSIONAL FEES				5,471	5,471
20	V	20 FEES, SUBSCRIPTIONS				351	351
21	V	21 CLERICAL AND GENERAL				14,762	14,762
22	V	24 EDUCATION/SEMINARS				230	230
23	V	26 INSURANCE				733	733
24	V	27 EMPLOYEE BENEFITS				328	328
25	V	30 DEPRECIATION				8,680	8,680
26	V	31 AMORTIZATION				1,852	1,852
27	V	32 INTEREST				12,925	12,925
28	V	33 REAL ESTATE TAXES				5,847	5,847
29	V	35 EQUIPMENT RENTAL				3,530	3,530
30	V						
31	V						
32	V	21 CLERICAL SALARIES				115,852	115,852
33	V	27 GEN ADMIN. - EMP. BEN.				36,279	36,279
34	V						
35	V	19 HOME OFFICE FEES	276,225	ITEX / AK CARE			(276,225)
36	V						
37	V						
38	V						
39	Total		\$ 276,225			\$ 224,089	\$ * (52,136)

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	17 ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 17,245	\$ 17,245
16	V	19 PROFESSIONAL FEES				113	113
17	V	20 FEES, SUBSCRIPTIONS				(216)	(216)
18	V	21 CLERICAL AND GENERAL				1,612	1,612
19	V	24 SEMINARS				51	51
20	V	27 GEN ADMIN.- EMP. BEN.				3,761	3,761
21	V						
22	V						
23	V						
24	V	19 MANAGEMENT FEES	22,212				(22,212)
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 22,212			\$ 22,566	\$ * 354

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535Report Period Beginning: 01/01/03Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 7

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	Owner	Administrative	28.67%	See Attached	7.00	10.77%		\$ 0		1
2	Jack Rajchenbach	Owner	Administrative	28.67%	See Attached	4.00	6.16%		0		2
3	Mark Hollander	Owner	Administrative	9.56%	See Attached	28.00	46.67%	mgmt fees	213,000	17-03	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 213,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab# 0040535

Report Period Beginning:

01/01/03Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ITEX COMPANYStreet Address 6633 N. LINCOLN AVE.City / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number (847) 679-9141Fax Number (847) 679-1820

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 DIETARY	AVAILABLE BED DAYS	466,105	5	\$ 21,664	\$	65,700	\$ 3,054	1
2	3 HOUSEKEEPING	AVAILABLE BED DAYS	466,105	5	62,013		65,700	8,741	2
3	5 UTILITIES	AVAILABLE BED DAYS	466,105	5	18,704		65,700	2,636	3
4	6 REPAIRS AND MAINT.	AVAILABLE BED DAYS	466,105	5	19,989		65,700	2,818	4
5	19 PROFESSIONAL FEES	AVAILABLE BED DAYS	466,105	5	38,816		65,700	5,471	5
6	20 FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	466,105	5	2,490		65,700	351	6
7	21 CLERICAL AND GENERAL	AVAILABLE BED DAYS	466,105	5	104,727		65,700	14,762	7
8	24 EDUCATION/SEMINARS	AVAILABLE BED DAYS	466,105	5	1,632		65,700	230	8
9	26 INSURANCE	AVAILABLE BED DAYS	466,105	5	5,200		65,700	733	9
10	27 EMPLOYEE BENEFITS	AVAILABLE BED DAYS	466,105	5	2,327		65,700	328	10
11	30 DEPRECIATION	AVAILABLE BED DAYS	466,105	5	61,580		65,700	8,680	11
12	31 AMORTIZATION	AVAILABLE BED DAYS	466,105	5	13,137		65,700	1,852	12
13	32 INTEREST	AVAILABLE BED DAYS	466,105	5	91,695		65,700	12,925	13
14	33 REAL ESTATE TAXES	AVAILABLE BED DAYS	466,105	5	41,479		65,700	5,847	14
15	35 EQUIPMENT RENTAL	AVAILABLE BED DAYS	466,105	5	25,042		65,700	3,530	15
16									16
17									17
18	21 CLERICAL SALARIES	DIRECT ALLOCATION		5	811,302	811,302		115,852	18
19	27 GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	254,060			36,279	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,575,857	\$ 811,302		\$ 224,089	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CAREPATH HEALTH NETWORK
 Street Address 6633 N LINCOLN AVENUE
 City / State / Zip Code LINCOLNWOOD, IL 60712
 Phone Number (888) 707-6700
 Fax Number (847) 679-2150

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17 ADMINISTRATIVE	CARE PATH FEES	339,037	13	\$ 263,221	\$ 263,221	22,212	\$ 17,245	1
2	19 PROFESSIONAL FEES	CARE PATH FEES	339,037	13	1,730		22,212	113	2
3	20 FEES, SUBSCRIPTIONS	CARE PATH FEES	339,037	13	(3,296)		22,212	(216)	3
4	21 CLERICAL AND GENERAL	CARE PATH FEES	339,037	13	24,604		22,212	1,612	4
5	24 SEMINARS	CARE PATH FEES	339,037	13	784		22,212	51	5
6	27 GEN ADMIN.- EMP. BEN.	CARE PATH FEES	339,037	13	57,412		22,212	3,761	6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 344,455	\$ 263,221		\$ 22,566	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Harmony Nursing And Rehab # 0040535 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	Cambridge		X	Mortgage	\$49,917.00	10/1/03	\$ 9,295,200	\$ 9,219,736	10/1/38	5.50%	\$ 75,822	1	
2	Prudential		X	Mortgage			9,317,100	0		7.38%	548,819	2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	Interest Income	X									(70,376)	6	
7	Interest Income		X								(643)	7	
8	See Supplemental Schedule							3,249,663			98,451	8	
9	TOTAL Facility Related				\$49,917.00		\$ 18,612,300	\$ 12,469,399			\$ 652,073	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 18,612,300	\$ 12,469,399			\$ 652,073	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 46,184 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
6												6	
7	TOTAL Long-Term											7	
	Working Capital												
8	Allocation from Itex		X				\$	\$			\$	12,925	8
9	Bank One		X	Working Capital				3,249,663		4.75%		93,398	9
10	Interest Income - Keiro	X										(7,872)	10
11													11
12													12
13													13
14	TOTAL Working Capital							3,249,663				98,451	14
	B. Non-Facility Related*												
15							\$	\$			\$		15
16													16
17													17
18													18
19													19
20	TOTAL Non-Facility Related												20

- * Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- ** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Harmony Nursing And Rehab**# **0040535**

Report Period Beginning:

01/01/03

Ending:

12/31/03**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.	\$	354,035	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	346,803	2
3. Under or (over) accrual (line 2 minus line 1).	\$	(7,232)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	358,004	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	350,772	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	324,101	8
	1999	321,925	9
	2000	379,027	10
	2001	337,175	11
	2002	340,956	12
2003 accrual = 2002 tax X 1.05			
340,956 X 1.05 = 358,004			
Allocation from Itex = 5847			
		FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2002	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing And Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>13-11-300-007-0000</u>	<u>Long Term Care Property</u>	\$ <u>340,956.12</u>	\$ <u>340,956.12</u>
2. <u>10-35-312-022-0000</u>	<u>Home Office Allocation</u>	\$ <u>41,478.56</u>	\$ <u>5,846.62</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>382,434.68</u>	\$ <u>346,802.74</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? XX YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harmony Nursing And Rehab COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0040535

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
2.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
3.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10.	<u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
		TOTALS	\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A.

Square Feet:

64,216

B.

General Construction Type:

Exterior

Masonry

Frame

Steel

Number of Stories

4

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☒ (a) Own the Equipment
 ☒ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)

List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

current amount = 65,032

2. Number of Years Over Which it is Being Amortized:

35

3. Current Period Amortization:

322,979

4. Dates Incurred:

1997 & 2003

Nature of Costs:

Old Amortization = loan costs of 377,250 remainder written off current period; currct amortization = loan costs of 65,032

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility		1994	\$ 600,000	1
2					2
3	TOTALS			\$ 600,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1994		11,156		20	621	621	5,555	9
10	Various		1996		9,553		20	477	477	3,715	10
11	Various		1997		8,612		20	431	431	2,922	11
12	Various		1998		12,911		20	646	(646)	3,619	12
13	Various		1999		61,368		20	3,068	3,068	14,526	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,039,152	180,072		351,957	171,885	3,174,304	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		277,463	6,673		9,028	2,355	93,366	68
69	Financial Statement Depreciation			10,960			(10,960)		69
70	TOTAL (lines 4 thru 69)		\$ 7,420,215	\$ 197,705		\$ 366,228	\$ 167,231	\$ 3,298,007	70

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 7,420,215	\$ 197,705		\$ 366,228	\$ 168,523	\$ 3,298,007		1
2	Emergency System	2000	19,300		20	965	965	3,297		2
3	Doorlock Safety	2000	1,174		20	59	59	177		3
4	Water Boiler	2000	1,486		20	74	74	222		4
5	Wallpaper Vinyl	2000	904		20	45	45	135		5
6	Window System	2000	647		20	32	32	96		6
7	Lighting	2000	1,174		20	59	59	177		7
8	Wooden Hook-Up	2000	1,737		20	87	87	261		8
9	Boiler Damper	2000	3,405		20	170	170	510		9
10	Dsl Cable Wire	2000	1,035		20	52	52	156		10
11	Radiator	2000	2,001		20	100	100	300		11
12	Thermostat	2000	2,548		20	127	127	381		12
13	Communication	2000	1,260		20	63	63	189		13
14	Fox Valley Heating	2001	11,600		20	580	580	1,353		14
15	Locks	2001	559		20	28	28	65		15
16	Locks	2001	559		20	28	28	58		16
17	Ac Repairs	2001	1,231		20	62	62	150		17
18	Door	2001	613		20	31	31	70		18
19	Parking Lot Sealcoat	2001	3,500		20	175	175	408		19
20	Cooler - Lock Bar	2001	789		20	39	39	81		20
21	Smoke Detector	2001	645		20	32	32	93		21
22	Single & Dual Jack	2001	581		20	29	29	75		22
23	Fire Equipment	2001	1,695		20	85	85	205		23
24	Chicago Sound & Communication	2002	5,000		20	1,000	1,000	1,667		24
25	Chicago Sound & Communication	2002	2,500		20	500	500	792		25
26	Water Heater	2002	2,599		20	217	217	343		26
27	Chgo Sound & Communication	2002	2,495		20	499	499	665		27
28	Windows	2002	647		20	32	32	62		28
29	Windows	2002	647		20	32	32	57		29
30	Windows	2002	705		20	35	35	59		30
31	Exit Signs	2002	537		20	27	27	45		31
32	Windows	2002	647		20	32	32	46		32
33	Windows	2002	705		20	35	35	50		33
34	TOTAL (lines 1 thru 33)		\$ 7,495,140	\$ 197,705		\$ 371,559	\$ 173,854	\$ 3,310,252		34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,495,140	\$ 197,705		\$ 371,559	\$ 173,854	\$ 3,310,252	1
2	Windows	2002	1,952		20	98	98	122	2
3	Windows	2002	1,988		20	99	99	116	3
4	Windows	2002	649		20	32	32	35	4
5	Water Heater Thermostat	2002	1,330		20	67	67	72	5
6	Call Buttons	2002	779		20	78	78	123	6
7	Walk In Freezer Door	2002	549		20	27	27	39	7
8	Walk In Freezer	2002	634		20	32	32	40	8
9	Condenser - Fan Motor	2002	508		20	25	25	30	9
10	Condensor Compressor	2002	802		20	40	40	43	10
11	Call System	2002	523		20	26	26	48	11
12	Central A/C Parts & Labor	2002	1,664		20	83	83	118	12
13	Smoke Detector	2002	536		20	27	27	34	13
14	Smoke Detector	2002	523		20	26	26	30	14
15	Automatic Door Unit	2003	5,606		20	420	420	420	15
16	Walk-In Compressor	2003	802		20	45	45	45	16
17	Cooler Compressor	2003	889		20	43	43	43	17
18	Heat Exchanger / Thermostat / Expansion Valve	2003	4,047		20	112	112	112	18
19	Dining Room Heater	2003	2,156		20	15	15	15	19
20	Wall Barriers	2003	733		20	49	49	49	20
21	Bell & Gossett Pumps	2003	2,491		20	249	249	249	21
22	Windows	2003	790		20	40	40	40	22
23	Windows	2003	1,057		20	35	35	35	23
24	Windows	2003	1,361		20	23	23	23	24
25	Pilot Assembly For Water Heater	2003	1,021		20	17	17	17	25
26	Pressure Pump Repair	2003	1,022		20	85	85	85	26
27	Peerless Pumps	2003	877		20	37	37	37	27
28	Pole Lights	2003	935		20	94	94	94	28
29	Freeze Plug Heater	2003	705		20	35	35	35	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

12/31/03

****Improvement type must be detailed in order for the cost report to be considered complete.**

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401	34

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12I, Carried Forward		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
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21								
22								
23								
24								
25								
26								
27								
28								
29								
30								
31								
32								
33								
34	TOTAL (lines 1 thru 33)		\$ 7,532,069	\$ 197,705		\$ 373,518	\$ 175,813	\$ 3,312,401

12/31/03

****Improvement type must be detailed in order for the cost report to be considered complete.**

XI. OWNERSHIP COSTS (continued)											
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.											
	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1994		\$ 7,019,409	\$ 179,985		\$ 350,970	\$ 170,985	\$ 3,165,842	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Keiro Building			1995	19,743	87		987	900	8,462	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.
 See Page 12A-BLDG, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,039,152	\$ 180,072		\$ 351,957	\$ 171,885	\$ 3,174,304	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)												
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.												
	1		2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4			1993		\$ 226,100	\$ 5,797	35	\$ 6,460	\$ 663	\$ 68,368	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Itex/A.K. Care			1993	28,450	343	20	1,423	1,080	15,230	9	
10	Itex/A.K. Care			1994	15,281	398	20	764	366	7,092	10	
11	Itex/A.K. Care			1995	2,604	7	20	130	123	1,067	11	
12	Itex/A.K. Care			1996	147	2	20	7	(5)	59	12	
13	Itex/A.K. Care			1997	4,393	113	20	220	107	1,428	13	
14	Itex/A.K. Care			1999	488	13	20	24	11	122	14	
15											15	
16											16	
17											17	
18											18	
19											19	
20											20	
21											21	
22											22	
23											23	
24											24	
25											25	
26											26	
27											27	
28											28	
29											29	
30											30	
31											31	
32											32	
33											33	
34											34	
35											35	
36											36	

*Total beds on this schedule must agree with page 2.
 See Page 12A-REP, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.
 SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 277,463	\$ 6,673		\$ 9,028	\$ 2,345	\$ 93,366	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,151,728	\$ 26,377	\$ 117,366	\$ 90,989	10	\$ 973,156	71
72	Current Year Purchases	13,991	1,783	2,177	394	10	2,177	72
73	Fully Depreciated Assets	29,286				10	29,286	73
74								74
75	TOTALS	\$ 1,195,005	\$ 28,160	\$ 119,543	\$ 91,383		\$ 1,004,619	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,327,074	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 225,865	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 493,061	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 267,196	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,317,020	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 13,650

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2003 Infinity	\$ 1,368.00	\$ 6,838	17
18	Facility	2004 Infinity	1,262.00	8,976	18
19					19
20					20
21	TOTAL		\$ 2,630.00	\$ 15,814	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	39 - 01	1608 hrs	\$ 52,441		
2	Licensed Speech and Language Development Therapist	39 - 01	1901 hrs	55,122					1,901	55,122	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	39 - 01	3211 hrs	121,885					3,211	121,885	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39 - 02	# of prescripts					200,341		200,341	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								
10	Academic Education		hrs								10
11	Exceptional Care Program										11
12											12
13	Other (specify): See Supplemental						5,398	53,421		58,819	13
14	TOTAL			\$ 229,448			\$ 19,738	\$ 253,762	6,720	\$ 502,948	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,008	\$ 308,572	1
2	Cash-Patient Deposits	37,401	37,401	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	962,446	962,446	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	140,166	182,262	6
7	Other Prepaid Expenses	327,625	327,625	7
8	Accounts Receivable (owners or related parties)	2,432,444	2,432,444	8
9	Other(specify): See Attached Schedule	7,089	552,159	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,933,179	\$ 4,802,909	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		7,019,409	14
15	Leasehold Improvements, at Historical Cost	110,124	113,524	15
16	Equipment, at Historical Cost	234,464	1,157,947	16
17	Accumulated Depreciation (book methods)	(205,485)	(2,756,302)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		65,032	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(465)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 139,103	\$ 6,199,145	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,072,282	\$ 11,002,054	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 288,969	\$ 339,504	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	40,193	40,193	28
29	Short-Term Notes Payable	3,219,842	3,249,664	29
30	Accrued Salaries Payable	139,843	139,843	30
31	Accrued Taxes Payable (excluding real estate taxes)	18,131	18,131	31
32	Accrued Real Estate Taxes(Sch.IX-B)		358,004	32
33	Accrued Interest Payable			33
34	Deferred Compensation	(62)	(62)	34
35	Federal and State Income Taxes	28,571	28,571	35
	Other Current Liabilities(specify):			
36	See Attached Schedule	79,545	79,545	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,815,032	\$ 4,253,393	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,219,736	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,219,736	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,815,032	\$ 13,473,129	46
47	TOTAL EQUITY (page 18, line 24)	\$ 257,250	\$ (2,471,075)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,072,282	\$ 11,002,054	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 464,815	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 464,815	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(207,565)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (207,565)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 257,250	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 8,406,426	1
2	Discounts and Allowances for all Levels	(656,953)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 7,749,473	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	661,287	6
7	Oxygen	1,845	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 663,132	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,970	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	16,967	15
16	Rental of Facility Space		16
17	Sale of Drugs	257,453	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	53,807	19
20	Radiology and X-Ray		20
21	Other Medical Services	99,323	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 444,520	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	71,019	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 71,019	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	37,784	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 37,784	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,965,928	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,540,940	31
32	Health Care	3,330,339	32
33	General Administration	2,198,096	33
B. Capital Expense			
34	Ownership	1,463,512	34
C. Ancillary Expense			
35	Special Cost Centers	542,056	35
36	Provider Participation Fee	98,550	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 9,173,493	40
41	Income before Income Taxes (line 30 minus line 40)**	(207,565)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (207,565)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Harmony Nursing And Rehab**# **0040535**Report Period Beginning: **01/01/03**Ending: **12/31/03****XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,702	1,846	\$ 67,504	\$ 36.57	1
2	Assistant Director of Nursing	2,000	2,264	61,502	27.17	2
3	Registered Nurses	36,034	39,643	870,638	21.96	3
4	Licensed Practical Nurses	12,215	13,017	248,583	19.10	4
5	Nurse Aides & Orderlies	121,252	127,720	1,131,624	8.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,602	8,598	229,448	26.69	7
8	Rehab/Therapy Aides	13,906	15,367	206,162	13.42	8
9	Activity Director	2,006	2,086	36,272	17.39	9
10	Activity Assistants	8,941	9,529	81,972	8.60	10
11	Social Service Workers	14,319	15,938	208,687	13.09	11
12	Dietician					12
13	Food Service Supervisor	2,738	3,140	74,403	23.70	13
14	Head Cook	2,137	2,473	22,825	9.23	14
15	Cook Helpers/Assistants	33,437	35,588	275,351	7.74	15
16	Dishwashers					16
17	Maintenance Workers	2,287	2,333	24,872	10.66	17
18	Housekeepers	40,834	44,703	366,151	8.19	18
19	Laundry	7,467	8,327	65,154	7.82	19
20	Administrator	1,880	2,080	90,378	43.45	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,310	13,369	156,617	11.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	10,276	11,101	133,724	12.05	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,448	1,480	22,986	15.53	33
34	TOTAL (lines 1 - 33)	334,791	360,602	\$ 4,374,853 *	\$ 12.13	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 9,888	01-03	35
36	Medical Director	monthly	18,000	09-03	36
37	Medical Records Consultant	monthly	4,248	10-03	37
38	Nurse Consultant	monthly	47,303	10-03	38
39	Pharmacist Consultant	monthly	5,584	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	50	2,350	11-03	44
45	Social Service Consultant	82	4,264	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	132	\$ 91,637		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Harmony Nursing And Rehab**# **0040535**Report Period Beginning: **01/01/03**Ending: **12/31/03**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions	
Name	Function	%		Description			Description	Amount
John Marc Sianghio	Administrator	0	\$ 90,378	Workers' Compensation Insurance	\$ 59,625		IDPH License Fee	\$ 200
				Unemployment Compensation Insurance	32,884		Advertising: Employee Recruitment	1,831
				FICA Taxes	333,119		Health Care Worker Background Check	950
				Employee Health Insurance	257,135		(Indicate # of checks performed <u>128</u>)	
				Employee Meals	54,203		Association Dues	7,376
				Illinois Municipal Retirement Fund (IMRF)*			Dues & Subscriptions	2,043
				Head Tax	8,066		Public Relations	36,667
				401K Expenses	3,551		Licenses	1,209
				Misc. Employee Benefits	4,613		Permits	150
				Employee Pension	52,735		See Supplemental Schedule	135
				Christmas Expense	14,850		Less: Public Relations Expense	(36,667)
							Non-allowable advertising	()
							Yellow page advertising	()
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 90,378	TOTAL (agree to Schedule V,	\$ 820,781		TOTAL (agree to Sch. V,	\$ 13,894
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees		G. Schedule of Travel and Seminar**		
Description			Amount	Description	Line #	Amount	Description	Amount
Management Fee - Mark Hollander			\$ 213,000				Out-of-State Travel	\$
							In-State Travel	
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 213,000					
(Attach a copy of any management service agreement)								
C. Professional Services								
Vendor/Payee	Type		Amount					
Power Software	Data Processing		\$ 7,640					
Medi Com	Data Processing		152					
A. K. Care	Bookkeeping Service		228,225					
Carepath	Bookkeeping Service		22,212					
Susan Fox	Accounting		8,715					
FR&R	Accounting		32,466					
A. K. Care	Accounting		48,000					
Stone McGuire	Legal		20,686				Seminar Expense	5,219
Winston & Strawn	Legal		12,420				Allocation from Itex	230
Harris, Kessler, Goldstein	Legal		4,264				Allocation from Carepath	51
Wilk & Waller (adj out p 5)	Legal		6,000					
See Supplemental Schedule			11,287				Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 402,067				line 24, col. 8)	\$ 5,500

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	None		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Harmony Nursing And Rehab**

STATE OF ILLINOIS

0040535

Report Period Beginning:

01/01/03

Ending:

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12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Council LTC: 10,044
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 41,223 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 98,550
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 54,203 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.